Mr and Mrs A Baxendale

Amelia House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Amelia House is a care home which is registered to provide care for up to 19 people. At the time of the inspection there were 16 people living at the home. The home specialises in the care of older people living with dementia but does not provide nursing care. The home is family run and the providers are very involved in the service on a day to day basis. One of the providers is the registered manager who is responsible for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way.

Summary of findings

People were encouraged and supported to maintain their independence. They made choices about their day to day lives which were respected by staff. There was a sense of purpose as people engaged with staff, watched what was going on, played games and pottered around the home. The majority of people were living with dementia and independently mobile, and staff engaged with them in ways which reflected people's individual needs and understanding.

People said the home was a safe place for them to live. One person said, "Oh yes it's very safe here. I like to come and go outside when I want and I have no worries." One relative said, "I'm sad that [X] is understanding less but I know they are in the best place." Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected.

People said they would speak with staff if they had any concerns and seemed happy to go over to staff and indicate if they needed any assistance. Staff were vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia. Relatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. One person said "I don't have any problems, I can't imagine why I would here."

People were well cared for and were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to choose. They were present with family when the care planning was discussed, for example some people living with dementia were able to say if they would like a key to their room or not. There were regular reviews of people's health, and staff responded promptly to changes in need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Medicines were well managed and stored in line with national guidance. Records were completed with no gaps, and medication with expiry dates was labelled with opening dates. There were regular audits of medication records and administration and to ensure that the correct medication stock levels were in place.

Staff had good knowledge of people, including their needs and preferences. Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. Comments about staff included, "They are all nice to me and know what they are doing" and, "They are very good, I have a nice home. They take me to the shops when I fancy a trip out".

People's privacy was respected. Staff ensured people kept in touch with family and friends. One relative told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private. We saw how staff positively supported relatives, especially where the behaviour of the person living at the home could be challenging due to their dementia.

People were provided with a variety of opportunities for activities and trips. These were individual as well as group organised, such as a trip to buy a new coat or choose toiletries, and a group outing to the local donkey sanctuary and the quay. People could choose to take part if they wished. Activities were not only organised events such as trips out and external entertainers but on-going day to day activities. For example, there was always something for people to do for stimulation such as chatting with staff, playing games, looking at books, household chores or just tidying or moving things. People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people walked around touching and moving things in a purposeful way. Staff were always visible to interact or sit with people. One person said, "There's lots going on. I like to sit in my room but I can see things going on from there which I like."

The registered manager and provider showed a great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people in individualised ways.

There were effective quality assurance processes in place to monitor care and plan on-going improvements. There were systems in place to share information and seek

Summary of findings

people's views about the running of the home, including relatives and stakeholders. People's views were acted upon where possible and practical, and included those living with dementia. Their views were valued and they were able to have meaningful input into the running of the home which mattered to them. For example, one person said they would like meal plates to be warm and another person had been appointed spokesperson for the residents' meeting.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People indicated they felt safe living at the home and with the staff who supported them. The provider had systems in place to make sure people were protected from abuse and avoidable harm.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Good

The service was effective.

People and/or their relatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs. Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had good understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect. Staff observed people's non-verbal signals to ensure they minimised any frustration or communication misunderstanding which helped to reduce possible anxiety or distress.

People and/or their relatives were consulted, listened to and their views were acted upon. Staff knew how to access advocacy services for people if they needed them.

Where people had specific wishes about the care they would like to receive at the end of their lives these were recorded in the care records. This ensured that all staff knew how the person wanted to be cared for at the end of their life.

Is the service responsive?

Good

The service was responsive.

People and/or their relatives were involved in planning and reviewing their care. They received personalised care and support which was responsive to their changing needs.

Summary of findings

People were helped to make choices about all aspects of their day to day lives where they could. People took part in social activities, had meaningful stimulation, trips out of the home, and were supported to follow their personal interests.

People, relatives and stakeholders shared their views on the care provided by the home. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Good

The service was well led.

People benefited from a service with an honest and open culture within the staff team. People were the focus of service provision and seen as individuals.

There were clear lines of accountability and responsibility within the management team. The providers ensured they monitored the quality and consistency of care.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed and the service took account of good practice guidelines.

Amelia House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 October 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by one inspector.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home.

At the last inspection carried out on 13 July 2013 we did not identify any concerns with the care provided to people who lived at the home.

At the time of this inspection there were 16 people living at the home and three vacancies. During the day we spoke with 10 people who lived at the home and one relative. As most people were unable to comment directly on their experience of the service we spent time observing care in the communal areas and took lunch with 11 people. We also spoke with the providers, the manager and five members of staff. We looked at a sample of records relating to the running of the home and to the care of individuals such as medication records, three staff files, quality assurance, audits and four individual care plans.

Good

Is the service safe?

Our findings

The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. One person said, "Oh yes it's very safe here. I like to come and go outside when I want and I have no worries". One relative said, "I'm sad that [X] is understanding less but I know they are in the best place". Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns and the local contact numbers were easily accessible. Staff were confident that any allegations made would be fully investigated to ensure people were protected. One relative had no concerns about how the home kept [their relative] safe. The provider had worked in partnership with the local safeguarding team relating to a recent incident, and given assurance that the person was safe, whilst enabling them to take reasonable risks.

The visitor said they felt the home was a safe place for people to live. They told us they would not hesitate to report concerns if they had any. They felt they would be listened to, and action would be taken to address any issues raised. One visitor said, "It was such a relief knowing that [my relative] was safe."

Staff encouraged and supported people to maintain their independence. There were risk assessments in place which identified risks and the control measures in place to minimise them. The balance between people's safety and their freedom was well managed. Some people were safely able to access the grounds on their own and keep their own door keys. Care plans showed what activities of daily living people could do or needed prompting with. Each element in people's care plans, such as mobility, nutrition and dementia, described what risks may arise and how staff should address them. For example, one person could choose what they wanted to wear, but sometimes chose inappropriate clothes for the weather, or did not remember to change soiled clothes. They could complete a task if staff initiated it and make choices more easily if there were fewer options. For example, if staff offered them a choice of two drinks. Staff were happy to help them if people needed assistance, but enabled people to maintain their independence for as long as possible.

We saw that individual risks to people had been discussed with them wherever possible. For example, people's choice to smoke was well managed. There were safety measures in place which helped people to feel they were making real choices, whilst remaining safe. One person told us how they knew they were safer if they did not keep their lighter on them all the time, and was happy to have access to one whenever they asked. Staff used diversion techniques, for example distracting people, if they forgot about the risks but also took the person to the shops if they wanted to buy another one. Risk assessments included whether people could use call bells, or whether people would choose to access the stairs. All areas were accessible for people and there were no barriers or gates. For example, people could access the stairs freely but assessments had been carried out to determine whether this might put them at risk. This meant that staff were aware of risks for people and opted for the least restrictive action. Therefore the staff had looked at the real risk for people and opted for the least restrictive action. There were enough staff visible at all times to ensure the safety of any person who would be at risk from accessing the stairs.

There were risk assessments relating to health such as skin pressure area risk, falls, and risks from having a short term memory. Each element of the computerised care plan involved a risk assessment chart which then gave a traffic light style risk rating. This made it easy to identify the areas of risk for each person at a glance. For example, one person was at high risk of weight loss, and risks related to their dementia and safety. The protective actions needed were clear in the care plans and had been put in place. For example, people had the appropriate equipment to keep them safe. One person had a specialist air mattress. The pressure reading was set correctly in relation to their weight. No-one at the home had any pressure sores and any vulnerable areas were identified and monitored. Staff also saw when people had gone to the bathroom independently and prompted them to wash their hands. The home also recognised seasonal risks such as hot and cold weather and acted accordingly to remind people to drink more or wear warm clothes. This information was also individualised, for example one person had always worked outdoors with animals and liked taking fresh air as they did not mind the cold.

The environment had been risk assessed and actions taken, for example radiator covers and window restrictors were in place, and there were no trip hazards. Legionella water checks were up to date. Staff had received regular fire safety instructions and fire drills from an external

Good

Is the service safe?

qualified instructor. All care plans contained individual person evacuation plans which included details about people's communication needs and mobility. One person's plan stated they would await rescue as they had limited sight, partial deafness and would be affected by loud noises. However, they would be able to understand basic instructions. These plans would be clear should the need arise to enable staff to keep people safe in an emergency situation.

The home was clean and homely. There was an infection control policy and staff were seen wearing appropriate personal protection equipment (PPE). Attention was paid to detail such as covers for people's water jugs. There were paper towels, liquid soap and clinical waste bins in use. One person used a hoist to mobilise and had a sling for their use only. The laundry was clean with a clear flow from dirty to clean, meaning there was no risk of cross contamination. There were washable surfaces and a locked cupboard where substances that were hazardous to health were stored safely.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. The two providers lived close by and had day to day input into the running of the home with one provider working as the registered manager. They were available on call at all times. The staff rota showed there was also a manager on duty during the day with a senior care worker and two care workers. The home employed a total of 15 care workers and rarely required agency cover. There was a cook and a domestic cleaner, which enabled care staff to concentrate on delivering care. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life.

We saw that people received care and support in a timely manner. Staff were very visible around the home throughout the day and vigilant in observing any signs that people required assistance, reassurance or displaying behaviour that could be challenging for staff. For example, one person liked to walk around with another person. Staff ensured the other person was happy to walk and when they seemed reluctant they enabled them to rest whilst staff accompanied the other person. This ensured there were no conflicts between these people and both were able to do what they wanted to do safely. We saw staff checked on people who were in their own rooms during our inspection. One person liked the quiet and watched TV in their room. Staff popped up to check they were ok and spent time with them which the person clearly enjoyed. Another person was having a lie down as they had been treated by the GP. Staff were quietly checking them so as not to disturb them but to ensure they were ok.

Care plans detailed what medication was for and how people's medication was administered. For example one person liked their tablets in a pot in front of them and a particular drink which they had. Plans included information about allergies and identified risks such as refusal. Staff noted medication refusals and informed the appropriate health professionals. For example, one person refused their eye drops and this had been reported. Whilst the care plan detailed "as required" medication and what it was for, further information was not within the medication administration records (MAR) about when to give this and what actions to consider before administration. The registered manager said they would now include this information within the MAR files as well as the care plans. No-one at the home were able to administer their own medication but there were policies and risk assessments in place should someone be able to in the future.

All staff who gave medicines were trained and had their competency assessed before they were able to do so. We saw medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received, and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. Each person had their medication administered separately. Staff explained to people what their medicines were for and ensured each person had taken them before signing the medication record. Opening dates were recorded on medication with use by dates.

A medicine fridge was available for medicines which needed to be stored at a low temperature which was monitored. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw these were stored and records kept in line with relevant

Good

Is the service safe?

legislation. The stock levels of these medicines were checked by two staff members regularly. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff.

Good

Is the service effective?

Our findings

There was a stable staff team at the home who had good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. They were also aware of what people had been doing recently. For example, staff chatted with one person asking about their time at their regular day centre visit. Another care worker knew that one person forgot when their family visited and was reassuring them of the time they had spent together recently.

People spoke highly of the staff who worked in the home. One person said, "Yes, I like it here. They really care for me." Other people were unable to reflect directly on their experiences but there was a friendly, open atmosphere and people were moving around the home freely and engaging happily with staff. In a recent survey sent by the home to health professionals' comments included, "Staff are always helpful and know what they are doing", There is continuity of staff who give good general and medical care in high quality accommodation" and "The staff are enthusiastic and I can't think of any least impressive aspects".

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. One care worker said, "I'm doing team leadership and management training. I'm very well supported." There was a computer training programme to make sure staff training was kept up to date. The training matrix showed staff were up to date or due for training soon. The registered manager was keen to invite external professionals to run additional training sessions for staff. One had been run on Dementia and the Environment by a local community psychiatric nurse. There were many examples around the home where advice arising from this training had been put into practice to further promote people's independence when living with dementia. This ensured staff had up to date knowledge of current good practice and showed they effectively used learning to benefit people living in the home.

Each new staff member received a comprehensive induction using workbooks in line with national guidelines Staff received regular one to one or group supervision where they could discuss issues such as their training needs. There were annual appraisals preceded by staff self-reviews which were then discussed and incorporated into a personal development plan.

We looked at three staff recruitment files. There were processes in place to ensure staff were appropriate to work with vulnerable people. For example, relevant police checks had been completed before people started work and appropriate references had been obtained. The job applications had lists of previous employment but no box to include dates. We asked the staff if there were any employment gaps which there weren't but the registered manager said they would rectify this to make this process more robust.

The home was well maintained and provided a pleasant and homely environment for people. There were different places for people to spend time such as a quieter room, activity area and TV room. People who lived in the home were involved in choosing colour schemes and furnishings. The registered manager was discussing a trip to a DIY store with people.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. Grab rails were bright red, as were toilet seats, around light switches and bathroom door frames. This enabled people living with dementia to maintain more independence. On each person's door there was their name and a framed picture board of things that were familiar to them. For example, one person always said they wanted to go home. Staff had recognised this meant their room although the person thought they were going to their home town. Staff had put the name of their home town on their door so they could easily find their room independently. People could access all areas of the home and people had individual walking aids, wheelchairs or adapted seating to support their mobility. The garden had a secure patio area and was safe for people to access independently. People were coming and going as they wanted to.

People had access to health care professionals to meet their specific needs. During the inspection we looked at four people's care records. These showed people had access to appropriate professionals such as GPs, dentists, district nurses and speech and language therapists. Currently people all used a large local surgery but the manager said people could choose other GPs if they

wished. This worked well for people at the home as they saw the same faces from one surgery such as district nurses. Three people received treatment from district nurses and staff were knowledgeable about how people were doing and what their progress was. The registered manager said, "We always include a care worker in health professional meetings so they have input". They said they had a good relationship with the surgery and could be assured that telephone messages would be picked up promptly. People said staff made sure they saw the relevant professional if they were unwell. One person said, "I have sore eyes and they keep an eye on me!"

There were regular reviews of people's health and staff responded to changes in need. One person with diabetes had been regularly monitored for example, and the podiatrist and GP had been involved. This demonstrated the staff were involving outside professionals to make sure people's needs were met.

Only one person had clear mental capacity to make important decisions about their care. The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well, and other professionals, where relevant. The care plans clearly discussed mental capacity and what people could understand. For example, care plans detailed what understanding people had and whether there was a named representative with power of attorney. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes.

Most people required some restrictions to be in place to keep them safe. The registered manager had made appropriate applications to the local authority to deprive people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and people's advocates. Staff continued to involve people in decision making which they could understand such as choices of clothes and food and drink or what they wanted to do. Even if people had been assessed as unsafe to leave the home independently, staff still enabled them to go out safely if they wished, for example, to the shops or for a walk.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. People had access to specialist equipment such as cutlery if necessary. One person required assistance with eating and drinking and this was done whilst maintaining their dignity. Staff sat with them at eye level and discreetly ensured they had adequate nutrition. The kitchen staff were aware of who had special diets such as caffeine free, and who had a small appetite. Diets were very personalised. For example, one person had a set routine of what and when they liked to eat. The staff had also encouraged them to try new meals with success. Another person had their meal cut up before it was given to them. The registered manager said they were in the process of compiling a photo menu book to enable people to choose meals more easily. Meals were home made using fresh fruit and vegetables and meat from a local butcher. There was a wide range of choices and people were able to suggest meals to include on the menu.

We took lunch with people. This was a sociable event in a pleasant environment with nicely laid tables. Staff took account of where people liked to sit and who with. People were not rushed and were treated with dignity and respect. Condiments and drinks were available. There were also snacks which people could access in between meals if they wished. Everyone we spoke with was happy with the food and drinks provided in the home and enjoyed the lunch of beef casserole and fresh vegetables. One person said "The food is lovely. We have a choice and we all say what we like. There's plenty of food and you can always have a snack if you are hungry." People were offered second helpings. Care workers also spent time making people teas and coffees whenever they asked and regularly asked people throughout the day, not just at set tea and coffee times.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff talked with us about individuals in the home. They had an excellent knowledge of each person and spoke about people in a compassionate, caring way. One person said "They are really nice people here. I can ask them anything."

Throughout the day we saw staff interacting with people who lived at the home in a caring and professional way. One staff member said, "I've been here a long time. I love it here. The residents are looked after very well. It's the best home I've worked in." Another staff member said, "The staff care for people very warmly. It is a lovely, friendly home". There was a good rapport between people, they chatted happily between themselves, and with staff and management.

We saw that some people used communal areas of the home and others chose to spend time in their own rooms. People had a call bell to alert staff if they required any assistance. They told us these were answered reasonably quickly and we saw they were during our inspection. We saw that staff always knocked on bedroom doors and waited for a response before entering. Staff noticed people's body language and attended to them to minimise any anxiety or distress.

Staff supported people who were in pain or distressed in a sensitive and discreet way. We saw one staff member comfort a person who had become very distressed. They treated the person with kindness and spent time with them to find out why they were upset. They offered them reassurance and the person was visibly calmer a few minutes later.

We saw people were able to make choices about their day to day lives. People chose what time they got up, when they went to bed and how they spent their day. Care plans showed details about people's choices, and families had been involved to create a comprehensive picture of people's preferences. When people regularly forgot things staff reminded them. For example, if people lost track of their conversation staff reduced their frustration by spending time doing activities with them. Staff ensured people communicated effectively, ensuring they were wearing their glasses and hearing aids for example. Where people expressed different choices their care plan was updated to the new routine but staff continued to offer a range of choices to enable people to change their minds. There were details of how to offer choices which people could understand. For example, one person responded well to a choice of two drinks to avoid them becoming more confused. One staff member was discussing different desserts from a cook book. They were going through pictures to choose the person's favourite dishes to encourage them to eat.

Each visitor we spoke with told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room. There was also a quiet lounge which some people chose to use, particularly if a number of visitors came at the same time, or a larger lounge upstairs. One visitor said "It's difficult to see my [relative] like this but the staff are very supportive and I can see they look after [X] well."

People's privacy was respected. All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw that bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff encouraged people to be as independent as they could be. People were able to orientate themselves around the home with the help of pictorial signs showing where bathrooms and toilets were for example. Staff were also aware where there were triggers which could develop into feelings of distress and anxiety for people. For example, one person found mirrors upsetting and staff had ensured they managed this effectively ensuring there were no mirrors in their vicinity.

We noted that staff never spoke about a person in front of other people at the home, which showed they were aware of issues of confidentiality. They acknowledged people as they moved around the home engaging in chat that was familiar to them, for example about places they had been or things they liked to talk about. For example, staff knew that one person had difficulty walking and the person had been able to say this had happened a long time ago when they had worked with horses. This gave staff additional understanding and a topic to start conversation with this person that they identified with. Another person had a

Good

Is the service caring?

musical past so staff ensured they were offered opportunities to take part in musical events. One person had been to a day centre that week and staff were chatting with them about this visit.

People were involved in decisions about the running of the home as well as their own care. The home had a very active 'resident's committee' who were able to discuss and influence life in the home despite the limitations of living with dementia. People could discuss any subject but usually spoke about activities and trips they would like to take part in and food they would like to see on the menu. One person told us how they were the spokesperson for the resident's meetings. They had suggested offering tours of the home for people living there who often became disorientated, and sometimes gave people a tour to remind them of their surroundings. People were listened to and their views taken into account. For example, one person had mentioned they would like to go to Dartmoor so the staff had spoken to the person's family about where on Dartmoor the person would like to visit so they could take them.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions. Other information included if people wanted to be involved in medical research, advance declarations of end of life choices, special instructions for funeral services and clearly stated when people had said they did not want to talk about this topic any more. Records also showed how and where people were more comfortable discussing sensitive issues. For example, one person felt more comfortable chatting in their room with the hairdresser so staff liaised with them to gain further information. Relatives were also able to stay with the person at the home when they were unwell. The provider said this had happened and there were camp beds available to enable families to be together.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone to ensure they could meet everyone's needs effectively. People were involved in discussing their needs and wishes and their relatives also contributed. The registered manager said "It's very important that we know we can meet people's needs. We have just assessed someone in hospital, but their needs would have meant we would not have been able to spend time as we do with everyone else, so we didn't take them."

During the inspection we read four people's care records. All were personal to the individual, which meant staff had details about each person's specific needs and how they liked to be supported. People living at the home and/or their families were involved in planning and reviewing their care. We saw people's care plans were discussed with them each month and changes were made if necessary. Some people had been able to sign some of their care records and the record of each monthly review. Other care plans said if the person had not wanted to be involved at that time. Where people lacked the capacity to make a decision for themselves, staff involved other professionals and family members in writing and reviewing plans of care.

Staff were aware of people's care plans and risk assessments and provided care in line with these assessments. For example, mobility assessments were very detailed. Staff knew what assistance people required, including gentle reminding to use their frames or sticks to keep safe. Most people were unable to ask directly for assistance. Staff were vigilant about observing when people were attempting to move independently, and went promptly to assist them.

People were supported to maintain contact with friends and family. Visitors said they were able to visit at any time and were always made welcome. People continued to be involved in the local community. If people had previously been involved in local clubs or day centres these were continued such as an Age UK day centre and Armed Forces club. Staff encouraged people to use local facilities such as shops and cafes. One person said "I like to get outside." This mirrored their care plan. Staff understood this person was used to an outdoor life and helped them to access the garden safely. Another person was looking like they wanted something to do so the provider took them to do some maintenance jobs which the person enjoyed. These were examples of the very individualised and responsive care which the home provided.

Staff at the home responded to people's changing needs. Care plans were kept up to date and staff also responded promptly to signs that people needed assistance. For example, one person started coughing and staff immediately took them a drink and checked they were ok. One person who was diabetic had seen a podiatrist and had their blood sugar levels monitored. Care plans also included body maps showing where people had a bruise or wound. These were monitored and signed off when the bruise or wound had healed. One person continued to have input by the district nurse and staff also monitored the wound. One daily record showed how a person had been a little more wheezy than usual, so the staff had called the GP. Any actions taken were recorded in care plans, which showed regular medication reviews for example. One person had been assessed by the speech and language therapist. Their food choice assessment in their care plan stated what diet they were on, and why, and from what date. Staff had then detailed what foods the person most liked, such as porridge with honey, and bread not toast, to ensure the special diet was also something they would eat.

All staff had an on-going responsibility for ensuring people received individualised engagement and stimulation. Throughout the day staff provided individualised meaningful occupation with people, noticing whether people were tired or whether they would like to do an activity. This could be looking at books, making art work such as wall hangings, (currently painting bird houses during this inspection) walking, going out or being read to. The home subscribed to the daily chat newsletter which was used to initiate conversations with people living with dementia. Staff were setting up a poets' corner and were enthusiastic on discussing future ideas to engage people. People's records showed on-going regular activities and engagement that was suited to them as individuals. For

Good

Is the service responsive?

example, one person said they fancied going to town and a date was set immediately. Staff had also suggested a staff photo-board, and this had become another activity involving people living at the home. The provider had often taken one person to the recycling centre which they liked. People were valued as individuals and there were regular birthday parties involving activities the person liked to do, such as Elvis karaoke.

There was a wide range of organised events from external entertainers and regular trips out in the home's people carrier. For example, people had visited the quay, been for a pub lunch, to local landmarks and to the donkey sanctuary where they had adopted a donkey. The home had links with the local church who visited the home.

People said they would not hesitate in speaking with staff if they had any concerns. Relatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. The complaints procedure was in the hallway and the formal complaints records were detailed and written in an understanding professional way. These complaints had been taken seriously and responded to in line with the provider's policy. The complainants had been advised of the outcome of the complaint investigations. The registered manager said they also intended to document any smaller concerns that arose to enable them to note any on-going patterns and further improve.

Good

Is the service well-led?

Our findings

There was a management structure in the home which provided clear lines of responsibility and accountability. The home was family run with the two providers being very involved in the day to day running of the home. One of the providers was the registered manager who had overall responsibility for the home. They were supported by a manager and a team of 15 care staff including senior care staff. People living at the home were assigned named key workers who had individual responsibility for individual needs such as ensuring they had toiletries and liaising with family members when gathering life history information for example. The home also had links with another service so they could share good practice.

The providers, manager and senior care staff were available throughout the inspection. We observed that all took an active role in the running of the home and had a good knowledge of the people who used the service and the staff. We saw that people appeared very comfortable and relaxed with the management team. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors. Staff said there was always a more senior person available for advice and support. They said "We get loads of support and any training we need. I'm doing a management qualification and we are encouraged to further our qualifications." Staff spoken with during the inspection described the management of the home as open and approachable. The registered manager showed a great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm, and this showed in the way they cared for people. One staff member said "You can't get a better home than this. It's so homely and the people living here are important to us."

The registered manager also worked occasional care shifts. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. For example, specialist health professionals were invited to give staff up to date training and this training had led directly to them identifying ways that the environment could be improved for people living with dementia.

There were regular staff meetings which included topical discussions about people's particular needs, time to discuss any issues raised by staff, and actions to raise from any audits. For example, staff were contacting the local Women's Institute to see if they could access their voluntary laundry and chatting service for people.

There were effective quality assurance systems in place to monitor care and plan ongoing improvements. There were audits and checks in place to monitor safety and quality of care. We saw that where shortfalls in the service had been identified action had been taken to improve practice. We looked at care plan audits that had been carried out and saw that any shortfalls had been addressed with staff. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them, including supervision and one to one discussion with staff. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

There were systems in place to share information and seek people's views about the running of the home. These views were acted upon where possible and practical. The service gained feedback from relatives and residents surveys, stakeholder surveys, complaints and compliments to continually develop the service. This enabled the home to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's wishes and needs. We saw that in response to the most recent survey the laundry process had been changed to ensure items were returned more quickly, and people had requested new staff name badges, a new menu, and warmer plates. Comments from the recent stakeholder's survey included, "The approachability of management is very good", "There is good general and medical care and high quality accommodation" and, "There are enthusiastic staff and continuity".

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.